STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for a State Residential Licensure Survey. Survey Dates: July 1, 2 and 3, 2013 Facility Number: 003916 Provider Number: 003916 AIM Number: N/A Survey Team: Karina Gates Generalist TC Beth Walsh RN Courtney Mujic RN Tom Stauss RN Census Bed Type: Residential: 59 Total: 59 Census Payor Type: Other: 59 Total: 59 Sample: 8 These state findings are cited in accordance with 410 IAC 16.2. Quality review 7/11/13 by Suzanne Williams, RN	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure the physician's order for daily weights was followed for 1 of 5 residents whose clinical records were reviewed in the sample of 8. Resident #255. Findings include: Resident #255's clinical record was reviewed on 7/2/2013 at 2 pm. Diagnoses included, but were not limited to, hypertension, COPD (chronic obstructive pulmonary disease), and edema. An MD order, dated 8/29/2012, indicated, "Daily weight: Call MD for > (greater than) 2 lbs in 24 hour, 5 lbs in 1 week (shoes on)." Resident #255's May, 2013 MAR (medication administration record) indicated the following daily weights: -on the 4th: 193.4 and on the 5th: 196.2 -on the 7th: 196.4, on the 8th: 199.8,	R000241	R241: (Failure to follow Dr. orders to report weight gain > 2 lbs.) What corrective actions will be accomplished for those residents who have been found to been affected by the deficient practice? * Henceforth and immediately as of 7/24 nursing will include documentation to support physician notification in either progress notes and or in MARs. Complete How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? * The facility immediately audited all resident medical charts for daily weights and parameters. Complete What measures will be put in place or what systemic changes will the facility make to ensure that this deficient practice does not recur? * Henceforth and going forward, the facility will place all weight orders in a confidential QA Nursing Communication Binder available only to licensed personnel. All licensed nursing personnel will be required to read, and initial the daily log before	07/31/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on the 9th: 201.8, on the 10th: 189.9 and on the 11th: 195.2 -on 20th: 193, on the 21st: 196, on the 22nd: 199.8, on the 23rd: 196, on the 24th: 197, on the 25th: 194.6, on the 26th: 198, on the 27th: 194.6, on the 28th: 201.2 and on the 29th: 198. Review of Resident #255's clinical record indicated documentation of notifying the MD of the above weight changes could not be found. An interview with the Director of Nursing on 7/3/2013 at 1:06 pm indicated the MD was not notified of the weight changes in May each day he had a weight change of greater than 2 lbs. She indicated the MD comes in at least twice a month and reviews the clinical records. She indicated staff at the facility primarily communicate with the MD through fax. She indicated she did not have any documentation of faxes in May relating to weight fluctuations. A "(MD name) Visit List for Next Rounding at Autumn Glen Assisted Living" sheet, provided by the Director of Nursing on 7/3/2013 at 1:50 pm, indicated, "Scheduled Date of Visit: May 16th. (Name of Resident #255) Concern: the symbol for arrow down (lower) extremitys [sic](legs) Bilat.		assuming shift responsibilities. Initials will verify responsibility for all previous prior physician orders. * The July 25th In-service will be used to implement and brief all licensed personnel on the systemic changes to communicating physician orders as well as re-briefing record documentation to support physician notification in either progress notes and or in MARs. Complete NLT 7/25/ 13How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? * The DON or a charge nurse will review the QA Nurse Communication Binder daily for shift compliance and signify with an initial on each page. Any licensed nursing associate missing a signature will be immediately notified to return and review the information. * An “End of Month Audit”, will be conducted monthly by the DON and or Charge Nurse and signed off for the QA Nursing Communication Binder and cross checked with the medical charts, as applicable, for compliance with weight reporting and other relevant provisions of care as may be listed in the confidential QA Nursing Communications Binder. Results of this audit will be recorded and placed behind the last day of the month’s page. *The QA requirement to conduct a monthly audit will be added to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(bilateral or both), swollen." An interview with the Director of Nursing on 7/3/2013 at 1:52 pm indicated she did not have any further documentation of staff follow-up on the days Resident #255's daily weights were greater than 2 lbs change in 24 hours during May 2013.		and cross checked with the Monthly Nursing QA checklist. to be completed NLT 7/31/13. By what date will the systemic changes be completed? * All actions have either been completed and or implemented, with the exception of finalizing a new Monthly QA Checklist which will be completed NLT 7/31/13. Thus, all actions will have been completed NLT 7/31/13. Reason For IDR * We have a letter from his physician stating that we did call in the weight changes. Autumn Glen Assisted Living, provider number 003916, is requesting an Independent Review face to face of R241 Health Services –Offense At issue here, and the evidence used to cite, is whether we followed doctor's orders and reported weight gains greater than 2 pounds for resident #255. We assert our staff did and can prove it using a letter from his physician, which we were unable to produce as this matter came up approximately one hour prior to the announced out-brief time on July 3rd. The administration of medications and the provision of residential nursing care shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call as follows: As we stated to the surveyor's our	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			nursing staff did it verbally usually by phone and rarely by fax but always as required. In a letter from the resident's physician (See attachment B, Letter from resident 255's physician) stating that we did maintain constant contact with her reporting weight changes as required. Thus we were in compliance and do not see where we violated this rule. That (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Medication aides (seems to have no relevancy here). We also take exception to the label this tag brings as an "offense". 410 IAC 16.2-5-1.1 defines an offense as follows…An offense presents a **substantial probability** that death or a life threatening condition **will** result. There was never a substantial probability of death nor did, as the word "will" supposes, a life threatening condition result because we called the doctor with his weights and his health has been under the care and scrutiny of his physician. Resident 255 is as baseline healthy today as he was then. Thus we are requesting a face to face hearing to put forward our contention that no offense has occurred and that R241 is not a proper or fair tag and should be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			removed from our record. Thank you for your time and attention. Please tell me where I can send or e mail the attachments. Sincerely, Thomas J. Knapik, Administrator, Autumn Glen Assisted Living 2250 Harvest Moon Dr. Indianapolis IN 46229 (317) 891-1508 or Admin@AutumnglenALF.com	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000406	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview, and record review, the facility failed to properly disinfect a blood glucose testing machine between resident use. This had the potential to affect 4 of 4 residents who received daily blood glucose testing on the 100/400 halls (#300, 50, 616, and 199). Findings include: During a random observation of blood glucose testing, on 7/2/13 at 11:44 a.m., for Resident #50, LPN #1 wiped off the blood glucose testing machine with alcohol wipes; no bleach wipes/solution were used to clean the machine at that time. During an interview with LPN #1, at the same time, LPN #1 indicated the blood glucose testing machine was shared between residents on the 100/400 hall. At 11:52 a.m., on 7/2/13, LPN #1 exited Resident #50's room after the blood glucose test and placed the blood glucose testing machine in the	R000406	R406: (Infection Control) What corrective actions will be accomplished for those residents who have been found to been affected by the deficient practice? * Immediately switched from manufacturer's (ARKRAY) blood glucose recommended Option 1 to recommended Option 2 (bleach) for cleaning and disinfecting the blood glucose meters on 7/3/13. (See Attachment 1. Completed 7/3/13). However upon arrival of new stronger chemicals and based on a recommendation from the Manufacturer we are now using Super Sani Cloth Germicidal disposable Wipes which is again Option 1. Complete 7/3/13 * Immediately in-serviced LPN#1 on ARKRAY recommended procedure to clean and disinfect the Assure Platinum blood glucose monitoring meters. Completed 7/3/13 * Immediately requested individual blood glucose meters be provided to all diabetic residents as recommended by the CDC. However, upon further review and based on a CLIA recommendation, each med cart will be equipped with 2 meters	07/31/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	100/400 medication (med) cart, without wiping off the blood glucose testing machine. On 7/2/13, at 12:06 p.m., LPN #1 pulled out the blood glucose testing machine from the med cart and wiped the blood glucose testing machine with alcohol wipes; no bleach wipes/solution were used to disinfect/clean the blood glucose testing machine at that time. LPN #1 then went into the dining room to assist Resident #616 back to her room for a blood glucose test. Resident #616 indicated she wanted to wait until after lunch to have the test administered, so LPN #1 then placed the blood glucose testing machine back into the 100/400 med cart. During the same time, LPN #1 indicated during an interview, she thought the blood glucose testing machine was cleaned with bleach wipes every shift and should be disinfected with bleach wipes/solution between each resident use. At 1:13 p.m., on 7/2/13, LPN #1 was observed walking down the hall towards the 100/400 med cart with (name of brand) non-professional, bleach-free wipes. During an interview with LPN #1, on		and residents will not individually possess their own meters as the manufacturer and CLIA understand the problems of correctly calibrating so many meters. Thus due to a risk benefit analysis it is felt that this system will besuperior. Complete * Immediately reviewed all diabetic resident files for possible infectious diseases such as HIV, Hepatitis B and C and C-diff, finding none. Complete * Immediately inserted into the 24 hour Com log Report Binder ARKRAY recommended procedures on how to clean and disinfect the blood glucose monitoring meters for review. Complete * Immediately Ordered and received additional germicidal back-up wipes with bleach and without as recommended by the ARKRAY representative so as not to run out. Complete * Contacted pharmacy and ARKRAY Manufacturer's Representatives for best practice recommendations which were presented in a special July 25 th in-service on disinfecting and cleaning the ARKRAY unit. Completed 7/25/13 How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? * The facility has identified all diabetic residents using a shared blood glucose meter and reviewed their records	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7/2/13 at 1:15 p.m., she indicated she always used alcohol wipes to clean the blood glucose machine previously, but was just given (name of brand) wipes to disinfect the blood glucose testing machine between resident use. On 7/2/13, at 1:17 p.m., LPN #1 was observed cleaning the blood glucose testing machine with the (name of brand) non-professional, bleach-free wipes. LPN #1 then performed Resident #616's blood glucose test. LPN #1 then exited Resident #616's room and cleaned the blood glucose testing machine with the (name of brand) non-professional, bleach-free wipes. At 3:00 p.m., on 7/2/13, the DoN (Director of Nursing) indicated the expectation was for staff to follow the manufacturer's policy for disinfecting the blood glucose testing machine. She also indicated the facility had been using the (name of brand) non-professional, bleach-free wipes for about a month, when the facility changed pharmacies. During a record review of a policy (no date) for (name of brand) blood glucose testing machine, received from the Administrator on 7/2/13 at		for symptoms of infectious blood borne pathogens, finding none. In addition we have implemented all actions listed above for all diabetic residents. Complete What measures will be put in place or what systemic changes will the facility make to ensure that this deficient practice does not recur? * We will add QA monitoring of cleaning and disinfecting of blood glucose meters to the specific checklist Monthly Nursing QA checklist. Complete by 7/31/13 * Ordered new and stronger chemicals as specifically recommended by the units's manufacturer to disinfect and clean a larger group of pathogens as recommended by the CDC. * In-serviced all nursing personnel as to specific procedures using specific chemicals as recommended by the CDC and the manufacturer. * Increased training and future training through specific in-services with insertion of yearly in-servicing of all licensed nursing personnel regarding recommended procedure for cleaning and disinfecting glucose monitoring meters beginning with the 6/25/13 in-service and yearly thereafter. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? * The Nursing QA Checklist for licensed nursing will contain an added check off item	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3:05 p.m., it indicated, "...to disinfect the meter, dilute 1 mL (milliliter) of household bleach (5-6% sodium hypochlorite solution) in 9 mL of water. This is a 1:10 dilution. The final concentration is 0.5-0.6% sodium hypochlorite." A review of the MSDS (Material Safety Data Sheet) for (name of brand) disinfecting, non-professional wipes, received from the Administrator, on 7/2/13 at 3:05 p.m., did not indicate a 0.5-0.6% sodium hypochlorite ingredient/solution, for the wipe. On 7/3/13 at 10:35 a.m., the Administrator indicated the facility ordered new disinfectant wipes the previous evening that contained the above bleach solution/ingredient. A list, titled Accuchecks, received from the DoN on 7/2/13 at 10:36 a.m., indicated 4 residents received daily blood glucose testing, on the 100/400 hall. On 7/3/13, at 10:42 a.m., the Administrator indicated the facility was using a bleach solution to disinfect the blood glucose testing machine previously, but they ran out of the solution a couple of days ago,		for spot checks of nursing compliance with recommended procedures as provided by the manufacturer's literature. By what date will the systemic changes be completed? All systemic changes that have not been completed immediately will be completed NLT 7/31/13 Reason For IDR: Autumn Glen Assisted Living, provider number 003916, is requesting an Independent Review face to face for R406 Infection Control- Offense Health Services –Offense The state has tagged us with an infection control offense because they contend the facility did not properly disinfect a blood glucose machine between resident use. It is our contention that LPN #1 removed an already cleaned, Blood Glucose meter from the cart as they are cleaned with bleach between shifts and again wiped it down with only alcohol, as it was clean, and used it to test Resident #50. LPN #1 states finding no wipes on the cart she set it down on a paper towel on the cart so as not to cross contaminate the cart. Before testing her next resident, she would again wipe it down with alcohol and then clean it with wipes provided to her. The wipes provided her were Clorox Disinfecting Wipes (without bleach); however as Clorox states, Clorox Disinfecting Wipes are a commercially available, EPA-registered disinfectant wipe	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	so someone went out to buy the non-professional, bleach-free wipes.		that contains a detergent. It is germicidal and considered to kill 99.9% of all germs. (See Attachment D from the Clorox Company) And we submit that Option 1 from the manufacturer's, (ARKRAY) handout How to Clean and Disinfect Your Blood Glucose Meter, (see attachment 1) where the manufacturer states…"Option 1 Cleaning and disinfecting can be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe", which we submit with evidence from the manufacturer, also describes Clorox Disinfecting Wipes which they state contains a disinfectant germicide and a detergent in the product. Thus we feel we were compliant. Note Option 2 uses a 1:10 concentration of bleach, which again, is optional. Even the CDC handout titled "Infection Prevention during Blood Glucose Monitoring and Insulin Administration" (See attachment 2, page 3 of 8) is only a recommendation. Under Best Practices for Assisted Blood Glucose Monitoring and Insulin Administration the word "recommendation" is carefully used in the first sentence of the first two paragraphs. The CDC uses the word "recommendation" not by accident, but picking their words carefully and understanding the difference between a recommended and a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			mandatory procedure. “Best practices” can and do change. Alcohol used to be the disinfectant of choice not just a common antiseptic. Only a few short years ago bleach itself was forbidden in facilities by the state, or so we were told and thus assumed many of us assumed it to be mandatorily forbidden. In any case best practices evolve, change and sometimes differ. We assert that we did indeed have a compliant practice but maybe not the "best practice" as interpreted by the ISDH. (See Attachment 2, page 6 of 8, titled “**Recommended** Practice for preventing Blood borne Pathogen Transmission during Blood Glucose Monitoring and Insulin Administration in Healthcare Settings”) Again notice the word “recommended”. The reason I bring this up is to add further evidence that we are being tagged based upon a recommended procedure, should not and probably is not mandated by either he State of Indiana, the CDC, or even ARKRAY the manufacturer. However, please note these recommendations have been immediately adopted as any intelligent provider would do when shown a better practice and for that we are thankful to our survey team for pointing out that we were not using optimal chemical disinfectant. Thus, labeling our practice as an offense seems arbitrary. In	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Residential Care Rule 5, 410 IAC 16.2-5-1.1 an offense is defined as follows…(1) An offense presents a **substantial probability** that **death** or a **life threatening** condition **will** result. Notice it did not say might result. It used the word will. If such were the case, then why would our procedure not be stopped immediately to save a life? I believe the answer is that there was not a substantial probability that death or a life threatening condition would (will) occur and without substantial **probability** of death or certainty of a life threatening condition, R406, must have been incorrectly applied. Without the benefit of using defined regulation on "best practices", how can there be consistency as applied between facilities? Thus we are requesting a face to face hearing to put forward and defend our contention that no "offense" has occurred. Thank you for your time and attention. Sincerely, Thomas J. Knapik, Administrator, Autumn Glen Assisted Living 2250 Harvest Moon Dr. Indianapolis IN 46229 (317) 891-1508 or Admin@AutumnglenALF.com	